FOR OHF USE

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037051

Facility Name: Glen Brook

Address: Route 45 North (Number) Vienna (City) 62995 (Zip Code)

County: Johnson

Telephone Number: 618-658-2005 **Fax #** 618-658-2005

IDPA ID Number: 371272698001

Date of Initial License for Current Owners: 08/08/95

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[X]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: James A. Keller **Telephone Number:** 618-833-5070 Ext. 15

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ April 25, 2002 (Date)
(Type or Print Name) James A. Keller
(Title) Administrator

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,742			5,742	13
14	TOTALS	5,742			5,742	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.32%

D. How many bed-hold days during this year were paid by Public Aid?
98 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 07/23/90

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/90 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	21,080	1,384	880	23,344		23,344		23,344			1
2	Food Purchase		42,422		42,422		42,422		42,422			2
3	Housekeeping		3,755	156	3,911		3,911		3,911			3
4	Laundry	15,997	818		16,815		16,815		16,815			4
5	Heat and Other Utilities			9,035	9,035		9,035		9,035			5
6	Maintenance		747	3,409	4,156		4,156	4,075	8,231			6
7	Other (specify):* Trash Removal			592	592		592		592			7
8	**TOTAL General Services**	37,077	49,126	14,072	100,275		100,275	4,075	104,350			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	42,750	3,686	480	46,916	85	47,001	876	47,877			10
10a	Therapy	95,552		798	96,350	(2,376)	93,974		93,974			10a
11	Activities		211	246	457	5,000	5,457		5,457			11
12	Social Services	18,612	34	2,468	21,114	(5,080)	16,034		16,034			12
13	Nurse Aide Training			1,857	1,857	2,291	4,148		4,148			13
14	Program Transportation			2,648	2,648		2,648		2,648			14
15	Other (specify):* DT Services			155,680	155,680		155,680	(154,372)	1,308			15
16	**TOTAL Health Care and Programs**	156,914	3,931	167,777	328,622	(80)	328,542	(153,496)	175,046			16
	C. General Administration											
17	Administrative	11,300			11,300		11,300		11,300			17
18	Directors Fees											18
19	Professional Services			22,264	22,264		22,264	(21,312)	952			19
20	Dues, Fees, Subscriptions & Promotions			1,810	1,810		1,810	(581)	1,229			20
21	Clerical & General Office Expenses		1,118	4,407	5,525		5,525	12,244	17,769			21
22	Employee Benefits & Payroll Taxes			23,540	23,540		23,540	3,742	27,282			22
23	Inservice Training & Education			1,470	1,470	(1,440)	30	106	136			23
24	Travel and Seminar			459	459	1,440	1,899	(68)	1,831			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			3,420	3,420		3,420	170	3,590			26
27	Other (specify):*			706	706	80	786	(130)	656			27
28	**TOTAL General Administration**	11,300	1,118	58,076	70,494	80	70,574	(5,829)	64,745			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	205,291	54,175	239,925	499,391		499,391	(155,250)	344,141			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Glen Brook #0037051 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			2,775	2,775		2,775	9,536	12,311			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			163	163		163	4,208	4,371			32
33	Real Estate Taxes			5,460	5,460		5,460		5,460			33
34	Rent-Facility & Grounds			38,400	38,400		38,400	(38,400)				34
35	Rent-Equipment & Vehicles			90	90		90		90			35
36	Other (specify):*			2,174	2,174		2,174	(573)	1,601			36
37	**TOTAL Ownership**			49,062	49,062		49,062	(25,229)	23,833			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		815		815		815		815			41
42	Provider Participation Fee			33,706	33,706		33,706		33,706			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		815	33,706	34,521		34,521		34,521			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	205,291	54,990	322,693	582,974		582,974	(180,479)	402,495			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,605	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(90)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(50)	27		24
25	Fund Raising, Advertising and Promotional	(374)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,174)	36		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(155,369)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (154,452)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(26,027)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (26,027)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (180,479)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Glen Brook

ID# 0037051

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Day Training	$ (154,372)	15	1
2	Funeral Flowers	(80)	27	2
3	PAC Dues	(77)	20	3
4	Johnson County Chamber of Commerce Dues	(40)	20	4
5	Overdraft Charges	(732)	21	5
6	Mansion Tour (Seminar)	(68)	24	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(155,369)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Glen Brook # 0037051 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	4,075	0	0	0	0	0	0	0	0	0	4,075	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	4,075	0	0	0	0	0	0	0	0	0	4,075	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	876	0	0	0	0	0	0	0	0	0	876	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(154,372)	0	0	0	0	0	0	0	0	0	0	(154,372)	15
16	**TOTAL Health Care and Programs**	(154,372)	876	0	0	0	0	0	0	0	0	0	(153,496)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(21,312)	0	0	0	0	0	0	0	0	0	(21,312)	19
20	Fees, Subscriptions & Promotions	(581)	0	0	0	0	0	0	0	0	0	0	(581)	20
21	Clerical & General Office Expenses	(732)	12,976	0	0	0	0	0	0	0	0	0	12,244	21
22	Employee Benefits & Payroll Taxes	0	3,742	0	0	0	0	0	0	0	0	0	3,742	22
23	Inservice Training & Education	0	106	0	0	0	0	0	0	0	0	0	106	23
24	Travel and Seminar	(68)	0	0	0	0	0	0	0	0	0	0	(68)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	170	0	0	0	0	0	0	0	0	0	170	26
27	Other (specify):*	(130)	0	0	0	0	0	0	0	0	0	0	(130)	27
28	**TOTAL General Administration**	(1,511)	(4,318)	0	0	0	0	0	0	0	0	0	(5,829)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(155,883)	633	0	0	0	0	0	0	0	0	0	(155,250)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Glen Brook # 0037051 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	3,605	5,931	0	0	0	0	0	0	0	0	0	9,536	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	4,208	0	0	0	0	0	0	0	0	0	4,208	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(38,400)	0	0	0	0	0	0	0	0	0	(38,400)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(2,174)	1,601	0	0	0	0	0	0	0	0	0	(573)	36
37	**TOTAL Ownership**	1,431	(26,660)	0	0	0	0	0	0	0	0	0	(25,229)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(154,452)	(26,027)	0	0	0	0	0	0	0	0	0	(180,479)	45

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
James A. Keller	50	Mulberry Manor	Anna	Kel-Tech Mgmt	Anna	Acct./Mgmt.
Norine J. Keller	50	Holly Hill	Anna	JR's Centre	Anna	Sheltered W/shop
		Lincoln Square	Jonesboro	ILS, Inc.	Anna	PPO DD CILA
		Pilot House	Cairo	J & J Partners	Anna	Bldg/Prop Lease
		Krypton	Metropolis	ILS Land Trust 94	Anna	Bldg/Prop Lease
		Liberty House	Marion			
		Colonial Manor	Ziegler			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Building Lease	$ 38,400	J & J Partners	0.00%	$	$ (38,400)	1
2	V	32	Mortgage Interest		J & J Partners	0.00%	4,208	4,208	2
3	V	30	Depreciation-Building		J & J Partners	0.00%	5,931	5,931	3
4	V	19	Management Services	21,600	Kel-Tech Management Co., Inc.	25.00%		(21,600)	4
5	V	6	General Maintenance/Wages		Kel-Tech Management Co., Inc.	25.00%	4,075	4,075	5
6	V	19	Legal/Accounting		Kel-Tech Management Co., Inc.	25.00%	288	288	6
7	V	21	General Office Expense		Kel-Tech Management Co., Inc.	25.00%	1,370	1,370	7
8	V	23	Total Staff Training		Kel-Tech Management Co., Inc.	25.00%	106	106	8
9	V	26	Insurance-Prop/Liab/Auto		Kel-Tech Management Co., Inc.	25.00%	170	170	9
10	V	36	General Capital Expense		Kel-Tech Management Co., Inc.	25.00%	1,601	1,601	10
11	V	10	Nursing Wages		Kel-Tech Management Co., Inc.	25.00%	876	876	11
12	V	21	Clerical Wages		Kel-Tech Management Co., Inc.	25.00%	11,606	11,606	12
13	V	22	Payroll Tax		Kel-Tech Management Co., Inc.	25.00%	3,742	3,742	13
14	Total			$ 60,000			$ 33,973	$ * (26,027)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	James A. Keller	Owner/Admin.	Administration	50.00	76,524	4	10.00	Admin.	$ 11,300	17-6	1
2	Norine J. Keller	Owner	Office/Director	50.00							2
3											3
4											4
5											5
6	Management Fee Allocation:	Indirect Cost									6
7	Don J. Pippins							Admin.	912	19-6	7
8	James A. Keller							Clerical	4,354	19-6	8
9	James M. Keller							Maintenance	11	19-6	9
10	Joshua C. Alley							Maintenance	129	19-6	10
11	Jacob L. Alley							Maintenance	3,224	19-6	11
12	Diana K. Alley							Staff Trainer	876	19-6	12
13								TOTAL	$ 20,806		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Kel-Tech Mgmt. Co., Inc.
Street Address: 158 East Vienna Street
City / State / Zip Code: Anna, IL 62906
Phone Number: (618-833-5070
Fax Number: (618-833-4993

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	% of Total Mgmt. Fee	290,400	10	$ 1,100	$	21,600	$ 82	1
2	5	Utilities	% of Total Mgmt. Fee	290,400	10	2,349		21,600	175	2
3	6	Maintenance	% of Total Mgmt. Fee	290,400	10	51,337	45,911	21,600	3,818	3
4	19	Legal & Accounting	% of Total Mgmt. Fee	290,400	10	3,880		21,600	289	4
5	20	Dues, Fees, Subscriptions	% of Total Mgmt. Fee	290,400	10	609		21,600	45	5
6	21	Clerical/General Office Exp.	% of Total Mgmt. Fee	290,400	10	173,847	156,041	21,600	12,931	6
7	22	Employee Benefits/PR Tax	% of Total Mgmt. Fee	290,400	10	50,307		21,600	3,742	7
8	24	Staff Training	% of Total Mgmt. Fee	290,400	10	1,422		21,600	106	8
9	13	DSP Training	% of Total Mgmt. Fee	290,400	10	11,776	11,776	21,600	876	9
10	26	Insurance-Prop/Liab/Auto	% of Total Mgmt. Fee	290,400	10	2,286		21,600	170	10
11	30	Depreciation	% of Total Mgmt. Fee	290,400	10	12,837		21,600	955	11
12	33	Real Estate Tax	% of Total Mgmt. Fee	290,400	10	1,488		21,600	111	12
13	34	Building Lease	% of Total Mgmt. Fee	290,400	10	7,200		21,600	536	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 320,438	$ 213,728		$ 23,836	25

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Anna National Bank		X	Auto Note Client Transport	$690.00	09/17/98	$ 24,824	$	09/17/01	0.0890	$ 163	1
2												2
3												3
4												4
5	Mortgage Interest from Related Party (Sch. VII B, Line 2)										4,208	5
	Working Capital											
6	James K. Keller	X		Working Capital		09/01/90	60,000	3,800				6
7												7
8												8
9	TOTAL Facility Related				$690.00		$ 84,824	$ 3,800			$ 4,371	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 84,824	$ 3,800			$ 4,371	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$ 6,070	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 5,460	2
3. Under or (over) accrual (line 2 minus line 1).	$ (610)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 6,070	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 5,460	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996	5,299	8
1997	5,321	9
1998	5,214	10
1999	5,260	11
2000	5,460	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Glen Brook COUNTY Johnson

FACILITY IDPH LICENSE NUMBER 0037051

CONTACT PERSON REGARDING THIS REPORT James A. Keller

TELEPHONE 618-833-5070 Ext. 15 FAX #: 618-833-4993

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	448	Woodcrest Hills Lot 24 & 25	$ 5,460.00	$ 5,460.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 5,460.00	$ 5,460.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,300 B. General Construction Type: Exterior Brick/Vinyl Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	73-ICF/MR	85,000	1989	$ 18,000	1
2					2
3	TOTALS	85,000		$ 18,000	3

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1990	1990	$ 220,501	$ 5,513	40	$ 5,513	$	$ 63,398	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Groundwork/Landscape			1990	2,156	108	20	108		1,242	9
10	Sidewalk/Driveway			1990	6,200	310	20	310		3,565	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 228,857	$ 5,931		$ 5,931	$	$ 68,205	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 8,913	$	$ 858	$ 858	10-20 Yrs.	$ 4,486	71
72	Current Year Purchases	1,779	1,779	179	(1,600)	5 Years	179	72
73	Fully Depreciated Assets	36,741					36,456	73
74								74
75	TOTALS	$ 47,433	$ 1,779	$ 1,037	$ (742)		$ 41,121	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Client Transport	1995 Ford Escort Wagon	1995	$ 12,956	$	$	$	5 Years	$ 12,956	76
77	Client Transport	1999 Ford 15 Pass. Van	1998	26,717	996	5,343	4,347	5 Years	18,701	77
78										78
79										79
80	TOTALS			$ 39,673	$ 996	$ 5,343	$ 4,347		$ 31,657	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 333,963	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 8,706	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 12,311	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,605	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 140,983	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: John R. Rendleman, Trustee, Glenbrook Land Trust 91

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1990	16	01/01/01	$ 38,400	10		3
4	Additions							4
5								5
6								6
7	TOTAL		16		$ 38,400			7

**

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 01/01/01
Ending 12/31/10

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2002	$ 38,400
13.	12/31/2003	$ 38,400
14.	12/31/2004	$ 38,400

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 90 Description: Water Cooler Rental
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 40

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 80

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)	43	834		877
4	Clinical Wages	(b)		2,156		2,156
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments		210	905		1,115
8	Nurse Aide Competency Tests					
9	TOTALS		$ 253	$ 3,895	$	$ 4,148
10	SUM OF line 9, col. 1 and 2	(e)	$ 4,148			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	5
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	5

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Glen Brook # 0037051 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 13,942	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	114,355		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	37		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	34,132		8
9	Other(specify): Prepaid Finance Charges	177		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 162,643	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	68,057		16
17	Accumulated Depreciation (book methods)	(104,279)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Furniture/Fixtures	37,716		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,494	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 164,137	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,697	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,070		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	2,174		35
	Other Current Liabilities(specify):			
36	N/P James K. Keller	3,800		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 13,741	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 13,741	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 150,396	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 164,137	$	48

***(See instructions.)**

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 150,338	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 150,338	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	142,890	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(142,832)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 58	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 150,396	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 567,351	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 567,351	3
	B. Ancillary Revenue		
4	Day Care	154,372	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 154,372	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	1,851	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,851	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Handling Fee	2,291	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,291	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 725,865	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	100,275	31
32	Health Care	328,622	32
33	General Administration	70,494	33
	B. Capital Expense		
34	Ownership	49,062	34
	C. Ancillary Expense		
35	Special Cost Centers	815	35
36	Provider Participation Fee	33,706	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 582,974	40
41	**Income before Income Taxes (line 30 minus line 40)****	142,891	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 142,891	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	510	566	5,061	8.94	9
10	Activity Assistants					10
11	Social Service Workers	1,530	1,698	15,183	8.94	11
12	Dietician					12
13	Food Service Supervisor	1,818	2,098	21,080	10.05	13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers					18
19	Laundry	1,652	1,729	15,997	9.25	19
20	Administrator	208	208	11,300	54.33	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,510	1,600	30,000	18.75	28
29	Resident Services Coordinator	670	700	12,751	18.22	29
30	Habilitation Aides (DD Homes)	12,656	12,926	93,919	7.27	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	20,554	21,525	$ 205,291 *	$ 9.54	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	32	$ 880	1-3	35
36	Medical Director	36	3,600	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	480	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	13	798	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	30	1,050	12-3	45
46	Other(specify)				46
47	Psychologist	30	1,339	12-3	47
48	Dental	12	1,200	15-3	48
49	TOTAL (lines 35 - 48)	165	$ 9,347		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
James A. Keller	Owner/Admin	50	$ 11,300
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 11,300

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Kel-Tech Mgmt. Co.	Management Services	$ 21,600
Barnett & Levine LLP	Accounting Services	555
FMGR	Legal Services	109
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 22,264

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 2,267
Unemployment Compensation Insurance	1,394
FICA Taxes	15,755
Employee Health Insurance	2,852
Employee Meals	63
Illinois Municipal Retirement Fund (IMRF)*	
Officer's Life	848
Cost Allocation to Related Party Sch. VII	3,742
Hepatitis Vaccinations	361
TOTAL (agree to Schedule V, line 22, col.8)	$ 27,282

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	84
(Indicate # of checks performed 7)	
Advertising/Contributions	464
IHCA Membership Dues	992
IL Secretary of State Franchise Tax	80
P. O. Box Rental/Sam's Club Dues	150
Johnson County Chamber of Commerce	40
Less IHCA PAC Dues	(77)
Less: Public Relations Expense	(40)
Non-allowable advertising	(464)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,229

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 1,440
In-State Travel	
Seminar Expense	
NADD Registration	459
Entertainment Expense	(68)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,831

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA 992**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? _____

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line _____

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES **X** NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
0036384 01/01/95

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **33,706**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **90%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.